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HEALTH and EXPOSURE HISTORY - ROCKY FLATS

PLEASE SELECT THE BEST ANSWER FOR EACH QUESTION. PLEASE USE A PEN TO FILL OUT THE QUESTIONNAIRE. WRITE CLEARLY.

For Office Use Only	Be	RAD	NDR	CHEM	BE Appt. Date	RAD Appt. Date	NDR Appt. Date	Termination Date
Date Entered: By:								

Date Completed / / | Employee No. | Social Security No.

Name

Last First Middle

Home Address

Street Apt. Number

Home Phone ( )

City/State/Zip

City State Zip Code

Sex ☐ Male(M) ☐ Female(F) | Age | Date of Birth / / | Place of Birth

City State

Race ☐ White (W) ☐ Black (B) ☐ Hispanic (H) ☐ Asian (A) ☐ Native American Indian (I) ☐ Other (O)

Marital Status: ☐ Never Married (N) ☐ Married (M) ☐ Widowed (W) ☐ Divorced (D) ☐ Separated (S)

Employment Status:
☐ RFP Current (RFPC) ☐ RFP Inactive (RFPI) ☐ Retired (R)
☐ DOE Current (DOEC) ☐ DOE Inactive (DOEI) ☐ Long Term Disability (LTD)
☐ WSI Current (WSIC) ☐ WSI Inactive (WSII)
☐ J A Jones Current (JAJC) ☐ J A Jones Inactive (JAJI)
☐ Sub Contractor, Current (SUBC) ☐ Sub Contractor, Inactive (SUBI)

Employed elsewhere? ☐ What type of work?

Of all the paid jobs you ever had, what KIND of work did you do the longest?

Last Year of Education Completed: ☐ 1 2 3 4 5 6 7 8 9 10 11 12 Primary Grades ☐ 13 14 15 16 College ☐ 17 Masters ☐ 18 Doctorate

Closest Living Relative

Name Relationship ( ) Phone

Street Apartment

City State Zip Code

Personal Physician

Name ( ) Phone

Health Status ☐ Excellent (E) ☐ Very Good (V) ☐ Good (G) ☐ Fair (F) ☐ Poor (P)

Statement of Your Present Health In Your Own Words

Do you have any work-related health changes? ☐ Yes ☐ No If yes please explain.

Have you had any illness which has left you with a physical or health problem? ☐ Yes ☐ No If yes please explain.

Has a doctor ever restricted your work or physical activities for medical reasons? ☐ Yes ☐ No If yes please explain.

Have you had any operation or surgery? ☐ Yes ☐ No If yes state reason for surgery, type of operation and date.
(Use back of page if more room required.)

When you do chores around your house /yard do you use chemicals such as pesticides, herbicides, etc? ☐ Yes ☐ No If yes please explain.

How often do you eat fruits & vegetables?
☐ Daily(D) ☐ 3-5 Times Week(3) ☐ 1-2 Times Week(1) ☐ 1-2 Times Month(M) ☐ Never(N)

Signature: _____ Date: _____

The information on this form is for medical use only and will not be released to unauthorized personnel.

 EXPOSURE HISTORY - Rocky Flats

Enter the number of ***YEARS EXPOSURE*** under the appropriate column for each material you worked with or were exposed to.

Chemicals	WORK BEFORE ROCKY FLATS	WORK AT ROCKY FLATS	WORK AFTER ROCKY FLATS	OTHER
101 Acrylimide				
102 Acetone				
103 Alcohol				
104 Ammonia				
105 Benzo(a)pyrine				
106 Benzene				
107 Benzidene				
108 1,3 Butadiene				
109 Carbon Disulfide				
110 Carbon Monoxide				
111 Carbon Tetrachloride				
112 Chloroform				
113 Ethylene Oxide				
114 Chlorine				
115 Chloroform				
116 Chromic Acid Mist				
117 Cutting Oils				
118 Cyanide				
119 Cyclohexane				
120 Ethyl Alcohol				
121 Freon				
122 Graphite				
123 Hydrogen Fluoride				
124 Hydrazine				
125 Hydrochloric Acid				
126 Hydrogen Peroxide				
127 Isocyanates				
128 Isopropyl Alcohol				
129 Fluorides				
130 Formaldehyde				
131 Nitric Acid				
132 Methyl Alcohol				
133 Methylene Chloride				
134 Methylene Dianiline				
135 Potassium Chromate				
136 Polychlorinated Biphenyls (PCB's)				
137 Pesticides				
138 Phenols				
139 Phosgene				
140 Plastics				
141 Propylene Oxide				
142 Percloroethylene				
143 Tetrabromoethylene				
144 Trichloroethylene				
145 Trichloroethane				
146 Toluene				
147 Uranyl Nitrate				
148 Vinyl Chloride				
149 Xylene				

EXPOSURE HISTORY - Rocky Flats

	WORK BEFORE ROCKY FLATS	WORK AT ROCKY FLATS	WORK AFTER ROCKY FLATS	OTHER
Paints/Adhesives				
301 Epoxy Resins				
302 Glues				
303 Paints (Spray)				
304 Roofing Material				
305 Solvents				
306 Turpentine				
Metals				
401 Ammunition Loading				
402 Antimony				
403 Arsenic				
404 Beryllium				
405 Cadmium				
406 Chromium (Chromates)				
407 Cobalt				
408 Lead				
409 Mercury				
410 Nickel				
411 Stainless Steel				
412 Titanium				
413 Welding Fumes				
414 Zinc				
Radiation				
501 Microwave				
502 Laser				
503 Americium				
504 Plutonium				
505 Thorium				
506 Tritium				
507 Uranium				
508 Radio Frequency				
509 X-Ray				
510 Electromagnetic				
Dusts/Particles				
601 Asbestos				
602 Ceramic Fibers				
603 Coal				
604 Fibreglass				
605 Sandblasting				
Other Hazards				
701 Loud Noise				
702 Loud Impact Noise				
703 Heat				
704 Cold				
705 Heights				
706 Vibration				
801 Other (List Below)				

Comments

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HEALTH and EXPOSURE HISTORY - ROCKY FLATS

Beryllium Health Surveillance Program

PLEASE SELECT THE BEST ANSWER FOR EACH QUESTION. PLEASE USE A PEN TO FILL OUT THE QUESTIONNAIRE. WRITE CLEARLY

Date Completed	Employee No	Social Security No	For Office Use Only Date Entered: By:

Name

Last First Middle

CURRENT EMPLOYEES PLEASE FILL IN EXTENSION, DEPARTMENT, AND BUILDING

Extension	Department	Building

EVERYONE PLEASE FILL IN THE FOLLOWING INFORMATION

While at Rocky Flats, did you ever work with beryllium? ☐ Yes ☐ No

While at Rocky Flats, did you feel you were ever exposed to beryllium? ☐ Yes ☐ No

During which years did you work with or do you feel that you were exposed to beryllium? 19_____ to 19_____

In what way(s) do you feel you may have been exposed to beryllium? _____

_____

Other than at Rocky Flats, did you ever work with beryllium? ☐ Yes ☐ No

If yes, where/name of company. _____

Did you ever work:

In a mine?	☐ Yes	☐ No	Year Started _____	Year Ended _____
In a quarry?	☐ Yes	☐ No	Year Started _____	Year Ended _____
In a foundry?	☐ Yes	☐ No	Year Started _____	Year Ended _____
In a pottery?	☐ Yes	☐ No	Year Started _____	Year Ended _____
With asbestos?	☐ Yes	☐ No	Year Started _____	Year Ended _____
In a cotton, flax or hemp mill?	☐ Yes	☐ No	Year Started _____	Year Ended _____

Please CIRCLE the appropriate response if you had any of the following conditions. Please provide the year diagnosed.

	Yes	No	Year Diag.
- Except when you have a cold (influenza), have you ever had an attack of wheezing that made you feel short of breath?	Y	N	_____
- Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?	Y	N	_____
- Do you ever have to stop to catch your breath when walking at your own pace on level ground?	Y	N	_____
- Do you have to walk slower than people of your age on level ground because of breathlessness?	Y	N	_____
- Are you presently taking any prescription medication for pulmonary (lung) problems?	Y	N	_____

If Yes, please list:

_____

_____

Signature: _____ **Date:** _____

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Comments

For Office Use Only

OCCUPATIONAL PROFILE - ROCKY FLATS

List the time period (month & year) that you worked at Rocky Flats. BEGIN (Mth/Yr): _____ END(Mth/Yr): _____
List the job(s) you held, the dates that you worked in this capacity, and the building(s) you worked in for each of these jobs while employed at Rocky Flats.

Job Title	Years (From - To)	Buildings

BEFORE WORKING AT ROCKY FLATS

EMPLOYMENT HISTORY
(Include Military History)

List in order from your first job until the time you went to work at Rocky Flats.

Job Title	Years (From - To)	Employer/City

AFTER WORKING AT ROCKY FLATS

EMPLOYMENT HISTORY
(Include Military History)

List in order from the time you left Rocky Flats until now.

Job Title	Years (From - To)	Employer/City

Personal Protective Equipment Used At Rocky Flats

	Please Check the Appropriate Box	
Noise		
Ear Plugs	☐ Yes	☐ No
Ear Muffs	☐ Yes	☐ No
Radiation		
Dosimeter	☐ Yes	☐ No
Film Badge	☐ Yes	☐ No
Gloves	☐ Yes	☐ No
Protective Clothing	☐ Yes	☐ No
Chemical Exposures		
Gloves	☐ Yes	☐ No
Protective Clothing	☐ Yes	☐ No
Respirator	☐ Yes	☐ No
Respirator Use		
1/2 Face	☐ Yes	☐ No
Full Face	☐ Yes	☐ No
Supplied Air	☐ Yes	☐ No
SCBA	☐ Yes	☐ No

FAMILY HISTORY | Please CIRCLE the appropriate response for each medical condition that anyone in your family had.

	Father or Father's Family	Mother or Mother's Family	Brother or Sister	Not Known
1 Cancer	F	M	B - S	U
2 Neurological Disease (Stroke, Epilepsy, Alzheimers, etc.)	F	M	B - S	U
3 Psychological Problems (Nervous Breakdown, Depression, etc.)	F	M	B - S	U
4 Respiratory Disease	F	M	B - S	U
5 Heart Disease	F	M	B - S	U
6 Kidney disease	F	M	B - S	U
7 Metabolic Disease (Diabetes, Thyroid, etc.)	F	M	B - S	U
8 Gastrointestinal Disease (Ulcers, etc.)	F	M	B - S	U
9 Musculo-Skeletal Disease (Arthritis, etc.)	F	M	B - S	U
10 Impairments (Speech, Vision, Hearing)	F	M	B - S	U
11 Reproductive Problems	F	M	B - S	U
12 Birth Defects	F	M	B - S	U
13 Immunological Problems	F	M	B - S	U
14 Alcohol Consumption	F	M	B - S	U
15 Tobacco Use (Smoking, Chewing)	F	M	B - S	U
16 Other	F	M	B - S	U

Comments: (Please feel free to enter any comments in this space.)

ADDITIONAL INFORMATION

Have you ever smoked? (No means less than 20 packs in a lifetime or less than 1 cigarette a day for a year). ..... Yes No
How old were you when you first started regular cigarette smoking? _____
If you stopped smoking cigarettes, how old were you when you quit? _____
Do you now smoke cigarettes? (In the last Month) ..... Yes No
How many cigarettes do you now smoke per day? _____
On the average, of the entire time you smoked, how many cigarettes did you smoke per day? _____
Do you, or did you inhale the cigarette smoke?
☐ Not at all (N) ☐ Slightly (S) ☐ Moderately (M) ☐ Deeply (D)

Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for 1 year.) ..... Yes No
How old were you when you first started regular cigar smoking? _____
If you stopped smoking cigars, how old were you when you quit? _____
Do you now smoke cigars? ..... Yes No
How many cigars do you now smoke per day? _____
On the average, of the entire time you smoked, how many cigars did you smoke per day? _____
Do you, or did you inhale the cigar smoke?
☐ Not at all (N) ☐ Slightly (S) ☐ Moderately (M) ☐ Deeply (D)

Have you ever smoked a pipe? ☐ Currently(C) ☐ Past(P) ☐ Never(N)
☐ Pipe(P) Years smoked _____
Ounces/Day (Circle one) 1or less 2 3 4 5 6 7 8 9 10 or more
Have you ever chewed tobacco? ☐ Currently(C) ☐ Past(P) ☐ Never(N)
☐ Chewed(C) Years chewed _____
Tins/Week (Circle one) 1or less 2 3 4 5 6 7 8 9 10 or more

Have you ever been exposed to other people's tobacco smoke (passive smoking)? ..... Yes No

At home by your parents?	Yes	No	If yes number of years:	_____
At home by your spouse(s)?	Yes	No	If yes number of years:	_____
At home by others?	Yes	No	If yes number of years:	_____
At work?	Yes	No	If yes number of years:	_____
In social situations?	Yes	No	If yes number of years:	_____
In the community?	Yes	No	If yes number of years:	_____

Alcoholic consumption. ☐ Currently(C) ☐ Past(P) ☐ Never(N) ☐ Occasionally(O)
Beer - Number of years: _____ (Average bottles/week): 1or less 2 3 4 5 6 7 8 9 10 or more
Wine - Number of years: _____ (Average glasses/week): 1or less 2 3 4 5 6 7 8 9 10 or more
Liquor - Number of years: _____ (Average ounces/week): 1or less 2 3 4 5 6 7 8 9 10 or more

If male, how many pregnancies have you fathered? _____
If female, how many pregnancies have you had? _____
How many living children do you have? _____
Have you fathered or conceived children from more than one marriage? ..... Yes No
If YES, how many children from each? _____
How many miscarriages have you had or has your wife (or wives) had? _____
How many children with birth defects have you had? _____
If you had children with birth defects please give dates of birth. _____

Comments: